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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **ERIK JOSEPH WILK, M.D.** **1117 State Street** **Santa Barbara, CA 93101-2712** **Physician's and Surgeon's Certificate No. A 63394,** Respondent.	Case No. 800-2019-055307 **FIRST AMENDED ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 29, 1997, the Board issued Physician's and Surgeon's Certificate Number A 63394 to Erik Joseph Wilk, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2022, unless renewed.

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JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

6. Section 2234 of the Code states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a

synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

8. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

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(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

9. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

10. Business and Professions Code section 125.3 states that:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

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(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

11. Respondent Erik Joseph Wilk, M.D. is subject to disciplinary action under section 2234, subdivision (c), of the Code for the commission of acts or omissions involving repeated negligent acts in the care and treatment of Patient 1.[1] The circumstances are as follows:

Patient 1

12. Patient 1 (or "patient") a then sixty-five-year-old female, who treated with Respondent from approximately 2014 through 2018.[2] Patient 1 suffered from various conditions including major depression[3] and chronic pain. Per CURES (Controlled Substance Utilization Review and Evaluation System, a drug monitoring database for Schedule II through V controlled substances dispensed in California), Respondent was prescribing to Patient 1 dangerous controlled medications including oxycodone (an opiate painkiller), hydrocodone (opiate painkiller), clonazepam/Klonopin (a Schedule IV benzodiazepine used to treat seizures, panic disorder, and anxiety), and alprazolam/Xanax (a benzodiazepine).[4]

13. During the above time period, Respondent treated the patient at her personal residence approximately once a month. Respondent did not have an office and only performed

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[1] The patient is identified by number to protect her privacy.

[2] These are approximate dates based on the records available to the Board.

[3] Specifically, Patient 1's depression and anxiety was brought upon by the prolonged illnesses and ultimate deaths of her parents and husband, spanning the period of 2004 to 2014. Patient 1 was the primary caregiver for her parents and husband.

[4] These controlled medications are also considered dangerous drugs pursuant to section 4022 of the Code. It should also be noted that the patient admitted to Respondent that she [i.e. the patient] would take opiates (e.g., hydrocodone), which should only be used for pain management not anxiety, when she felt depressed and emotionally overwhelmed with her life stressors. The patient also confided in with Respondent that she [i.e., the patient] drank alcohol on occasion to reduce her pain.

house calls. Patient 1 was referred to Respondent to manage her chronic pain. Respondent did not perform any tests prior to prescribing the patient medications nor did he consult with her prior treating orthopedist or obtain her medical records.[5] The patient subsequently filed a complaint against Respondent alleging that Respondent prescribed excessive amounts of benzodiazepines, opiates, and anti-depressants, which resulted in significant personal life issues for her.[6]

14. Respondent committed the following acts and/or omissions in his care and treatment of Patient 1 which represent simple departures from the standard of care:

A. The failure to offer non-opiate management of chronic pain and the failure to adequately corroborate the severity of the patient's pain;

B. The failure to perform appropriate opioid risk stratification;[7]

C. The absence of multi-disciplinary pain management in treating the patient who had elevated addiction risks;

D. The failure to perform routine urine toxicology screens, and the failure to review CURES (or keep copies in patient's chart) to ensure medication compliance and rule out prescriptions from other sources;

E. The decision to prescribe long term opiate therapy to a 65-year-old patient;

F. The failure to offer naloxone therapy to the patient who was on an excessive MED (Morphine Equivalent Dose);[8]

G. The decision to prescribe two short acting narcotics (oxycodone and hydrocodone) with similar pharmacokinetics, thereby exposing the patient to an increased risk of addiction and toxicity;

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[5] Despite Respondent's assertion that he examined the patient during the majority of the house calls, it appeared from the records that monthly prescriptions were simply refilled without thorough assessments. Moreover, per the records, there was not one single urine testing during the three and a half years of chronic opiate pain management, and no documentation that Respondent frequently queried CURES.

[6] According to the patient, she, not the Respondent, would often self-taper down the medications. Specifically, the patient asserted that from approximately June 2015 through August 2015, Respondent had her on such a high dose of oxycodone and hydrocodone at the same time, that she refused to take the oxycodone.

[7] The patient's major depression, anxiety and occasional drinking all pointed toward an increased risk of opiate dependency. Respondent failed to recognize these addiction risks as he failed to perform a proper risk stratification prior to initiating long term opiate therapy in 2014.

[8] MED are values that represent the potency of an opioid dose relative to morphine. Patients taking 50 or greater MED daily are more at risk for problems related to opioid use. Very high dosages are 90 or greater MED a day. As the patient was receiving more than 100 tablets of narcotics monthly, opiate diversion and compliance should be closely monitored.

H. Inadequate chart documentation in opiate monitoring;

I. The failure to refer Patient 1 for a mental health consultation;

J. The failure to adequately perform a comprehensive anxiety evaluation, and the decision to rely on long term benzodiazepine therapy to manage General Anxiety Disorder;

K. Prescribing two benzodiazepines for anxiety management; and

L. Concurrent prescribing of two benzodiazepines (clonazepam and lorazepam/alprazolam) and opiates.

15. The above acts or omissions constitute repeated negligent acts under the Code, and therefore subject Respondent's medical license to discipline.

SECOND CAUSE FOR DISCIPLINE

(Excessive Prescribing)

16. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Erik Joseph Wilk, M.D. is subject to disciplinary action under section 725 of the Code, in that Respondent excessively prescribed dangerous drugs to Patient 1, above.

THIRD CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Prior Examination or Medical Indication)

17. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Erik Joseph Wilk, M.D. is subject to disciplinary action under section 2242 of the Code, in that Respondent furnished dangerous drugs to Patient 1 above, without conducting an appropriate prior examination and/or medical indication.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

18. By reason of the facts and allegations set forth in the First Cause for Discipline above, Respondent Erik Joseph Wilk, M.D. is subject to disciplinary action under section 2266 of the Code, in that Respondent failed to maintain adequate and accurate records of his care and treatment of Patient 1 above.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 63394, issued to Respondent Erik Joseph Wilk, M.D.;

2. Revoking, suspending or denying approval of Respondent Erik Joseph Wilk, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Erik Joseph Wilk, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: AUG 0 9 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant